A Consideration to the Strategy Report

The *Overlooked Epidemic*

to Make Our Children *Healthy* Again

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Prenatal Alcohol Exposure Related to Mental Health, Justice, Education, Society, and Work in America

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A Case for including Prenatal Alcohol Exposure (PAE) and Fetal Alcohol Spectrum Disorders (FASD) in the National Mental Health Policy

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End Childhood Chronic Disease

Since the late 1960s, every administration has repeated the same oversight: failing to acknowledge the profound impact of Prenatal Alcohol Exposure (PAE) and Fetal Alcohol Spectrum Disorders (FASD). For decades, national policy has looked past this hidden epidemic, leaving families to navigate alone and systems to shoulder escalating costs. What makes the current moment especially troubling is that the MAHA Report—intended to guide today's policy decisions—presents a picture that is woefully incomplete. By omitting PAE/FASD, it leaves leaders to act on partial truths while families, schools, and communities bear the full weight of the consequences.

The United States has mobilized billions in federal resources to confront the opioid epidemic, which affects about 2.1 million Americans—roughly 0.6% of the population. In stark contrast, FASD, which is more than ten times as prevalent, remains largely invisible in national mental health and chronic disease policy—including both the Mental Health Assessment for Healing America (MAHA) Report and the more recent Make Our Children Healthy Again Strategy Report.

Yet the moment for change is now. With unprecedented national attention on youth mental health and prevention, we have a narrow but powerful window to correct this omission, reshape policy, and finally tell the whole truth.
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Executive Summary

The MAHA Strategy (2025)/Make Our Children Healthy Again calls for bold prevention campaigns on alcohol, THC, vaping, and other risks to youth health. These are important steps. Yet it fails to name the most devastating and preventable form of alcohol harm: prenatal exposure.

Prenatal Alcohol Exposure (PAE) and the resulting Fetal Alcohol Spectrum Disorders (FASD) are the overlooked epidemic of our time—affecting far more Americans than opioid use disorder, autism, or many of the conditions that dominate national attention. The science is clear: PAE disrupts brain development in ways that shape lifelong outcomes across every domain of health, behavior, and society. But because PAE/FASD is left invisible in national policy, children, families, and entire communities remain caught in cycles of failure.

This consideration challenges the omissions of the MAHA Strategy and demonstrates how the failure to recognize PAE/FASD undermines the nation's response to its most urgent crises.

Across five domains, the evidence is overwhelming:

- ***Mental Health & Chronic Disease***: Misdiagnosis fuels failed treatments, leaving families and providers exhausted while a major preventable neurodevelopmental condition goes unaddressed.
- ***Criminal Justice***: Misinterpretation punishes disability as if it were choice—youth with FASD are up to 19 times more likely to be incarcerated.
- ***Education***: Mislabeling bounces students from one false label to another, pushing them out of classrooms ill-equipped to meet their needs.
- ***Society***: Unrecognized FASD fuels homelessness, child welfare involvement, vulnerability to exploitation, and even risks to community safety.
- ***Careers***: Employment instability silences potential, drains productivity, and perpetuates intergenerational poverty.

Imagine if national policy named PAE/FASD for what it is: the missing cornerstone of America's mental health and chronic disease strategy. With recognition, prevention becomes possible, interventions become effective, and children and families gain a real chance to thrive.

— Scope of the Impact —

The MAHA Strategy frames chronic disease as one of the greatest threats to America's health, pointing to poor diet, chemical exposure, chronic stress, and overmedicalization as key drivers. Yet it fails to recognize PAE—a root cause that disrupts brain development before birth and sets the stage for lifelong vulnerability across every domain of health and society.

The evidence is undeniable:

- ***Prevalence***: Fetal Alcohol Spectrum Disorders (FASD) affect an estimated 7.1%[1] of Americans—nearly 25 million people. This is more than ten times the prevalence of opioid use disorder.
- ***Prenatal Exposure***: Approximately 14%[2] of pregnancies involve alcohol use—meaning nearly one in seven children begins life with measurable risk.
- ***Mental Health***: Individuals with FASD face staggering rates of comorbidity.[3] Studies show 38% experience anxiety disorders, 46% mood disorders, and 25.9% report suicidality with adolescent rates even higher.[4,5,6,7] PAE disrupts brain development, which shapes emotional, cognitive, and behavioral health in ways that echo, intensify, or even prefigure many lifelong vulnerabilities to mental health conditions.[8,9]
- ***Criminal Justice***: Youth with FASD are up to 19 times more likely to be incarcerated than their peers.[10]
- ***Education***: The majority of students with FASD are misdiagnosed with ADHD, ODD, or other conditions, leading to repeated suspensions, dropout risk, and academic failure.[11,12,13,14,15,16]
- ***Societal Costs***: Each individual with FASD is estimated to carry $22,810 per year in extra societal costs—adding up to billions annually.[17,18,19,20]
- ***Careers***: More than 80% of adults with FASD experience chronic unemployment or underemployment, starting with our youth, silencing potential and perpetuating poverty.[21,22,23]

These are not isolated statistics—they are interconnected outcomes of a largely preventable, brain-based disability that remains hidden in plain sight. Prenatal Alcohol Exposure doesn't just alter brain development; it also increases risks for chronic disease across the lifespan, including liver dysfunction, heart disease, metabolic disorders, and autoimmune conditions. If MAHA is serious about addressing chronic disease, it cannot ignore the most preventable neurodevelopmental condition driving cycles of mental illness, educational failure, justice involvement, and intergenerational poverty.

— The Cost of Omission —

The MAHA Strategy calls for bold action on the financial and social burden of chronic disease. Yet by omitting PAE/FASD, it overlooks one of the most costly and largely preventable drivers of dysfunction across every system.

The costs of omission are staggering:

- ***Economic Waste***: Schools, clinics, and justice systems spend billions cycling through treatments and interventions that fail, because they target symptoms while ignoring the root cause. Resources are poured into broken pipelines, while prevention and tailored support remain unfunded.[24,25,26]
- ***System Burnout***: Families are told they are noncompliant, providers grow frustrated by repeated treatment failures, and educators exhaust themselves managing behaviors they were never trained to understand. Blindness to PAE leaves entire systems chasing solutions that cannot succeed.[27,28]
- ***Human Toll***: Children are mislabeled as defiant, parents blamed for lack of discipline, and young adults dismissed from jobs for "poor performance." These are not character flaws—they are brain-based disabilities misinterpreted as choice. Without explicit inclusion, suicide prevention efforts fail to reach one of the most vulnerable groups—those with FASD.[29,30] The emotional and relational costs are immeasurable.[31]
- ***Tertiary Safety Risks***: When FASD is unrecognized, vulnerabilities escalate into broader crises—homelessness, child welfare involvement, trafficking, and even community safety concerns.[32] Jody Crowe's Book *The Fatal Link* found that as many as 80% of school shooters had probable or confirmed FASD—a sobering reminder of what is at stake when prevention and recognition fail.[33]

Imagine the difference if these billions were redirected from crisis management to prevention and targeted support. Imagine schools where teachers understood disability, courts where probation officers adjusted expectations, and clinics where providers treated the root cause. Recognizing FASD is not just compassionate policy—it is the most cost-effective investment America can make.

— Recommendations & Solutions —

The MAHA Strategy has opened a national conversation about prevention, chronic disease, and youth mental health. To fulfill that promise, PAE/FASD must be named and addressed directly. Recognition is the key that unlocks real progress.

We recommend the following actions to also be included:

National Recognition of FASD

- Formally include PAE/FASD in federal mental health and chronic disease strategies.
- Establish FASD as a named category within public health, education, and justice policy frameworks.[34,35]

Targeted Prevention Campaigns

- Launch nationwide awareness campaigns on prenatal alcohol use—parallel to efforts on vaping, THC, and opioids.
- Provide clear, evidence-based messaging that no amount of alcohol during pregnancy is safe.

Workforce Training & Capacity Building

- Equip mental health providers, educators, probation officers, and social workers with FASD-specific training.[34,35]
- Integrate FASD into medical, nursing, psychology, and teacher preparation programs.

Integrated Support Systems

- Establish coordinated care models where therapists, pediatricians, teachers, and parents (when available) communicate regularly.
- Break down silos so families receive consistent strategies instead of conflicting advice.

Early Identification & School Support

- Implement routine screening for prenatal exposure in pediatric and educational settings.
- Develop Individualized Education Plans (IEPs) and classroom strategies tailored to neurocognitive differences.[36]

Justice Reform

- Integrate FASD screening at every stage of juvenile and criminal justice involvement.
- Provide diversion programs and probation supports that recognize brain-based disability rather than punishing it.[37]

Employment & Independence Pathways

- Expand supported employment, job coaching, and vocational rehabilitation tailored to FASD.[38]
- Incentivize businesses to hire and retain individuals with FASD by offering training and support subsidies.

Family & Community Supports

- Invest in respite care, peer support networks, and family training.
- Expand housing, mentoring, and transition services for adolescents and adults with FASD.

Imagine a future where prevention reduces prevalence, recognition unlocks appropriate treatment, and support strategies transform outcomes. Imagine schools where children with FASD are understood, justice systems that deliver fairness, workplaces that embrace potential, and communities that thrive. This is not a distant dream—it is the achievable future of America if PAE/FASD is finally named and addressed.

Mental Health Outcomes

What MAHA Says

The MAHA Report rightly emphasizes the urgency of America's mental health crisis. It calls for expanding access, reducing stigma, building the workforce, and integrating behavioral health into healthcare. These are noble priorities that deserve national commitment.

What MAHA Leaves Out

Yet without naming Prenatal Alcohol Exposure (PAE) and Fetal Alcohol Spectrum Disorders (FASD), these strategies rest on a shaky foundation. PAE disrupts brain development before birth, shaping emotional, cognitive, and behavioral health in ways that echo across a lifetime. Research shows individuals with FASD face staggering rates of comorbidity: nearly 40% live with anxiety disorders, 46% with mood disorders, and over 25% report suicidality—with adolescents at even higher risk. [39,40,41,42]

Behind these statistics are real children and families:

- A child bounced from one diagnosis to another, with treatment after treatment that never works.
- A teenager prescribed medication after medication, yet still sinking deeper into despair.
- A parent blamed for "noncompliance," when the real issue is a brain-based disability.
- A provider left frustrated, mistaking neurological limitations for resistance.

These are not failures of families or clinicians. They are failures of a system blind to the root cause.

The Consequences of Omission

Standard interventions such as Cognitive Behavioral Therapy (CBT)—implicitly assumed in MAHA's framework as effective—routinely fall short for individuals with FASD. CBT requires memory, abstraction, and executive functioning skills that many cannot consistently apply.[43,44] Without FASD-specific training, even the best-resourced systems will continue to misdiagnose, mistreat, and exhaust families and providers alike.

The cost is measured not just in dollars, but in lives: children mislabeled as defiant, parents crushed by blame, and providers cycling through therapies that cannot succeed. Each misdiagnosis fuels treatment failure, deepening frustration across every level of care.

For millions of us, this looked like years of appointments—our children diagnosed with ADHD, autism, then bipolar disorder, then oppositional defiant disorder—yet no treatment worked. The truth was not defiance or resistance; It was FASD, hidden in plain sight.

We brought our son home from the hospital knowing his birth mother drank alcohol during pregnancy. Yet it took us fourteen years to understand the root cause of his behavioral symptoms. Once we finally named FASD, we could begin to educate ourselves and respond differently. What had once been chaos—24 hours a day, seven days a week—is now, eight years later, less than 2% of our daily life.. ~ Joel Sheagren

Evidence-Based Solutions

Imagine if providers were trained to recognize FASD early—able to distinguish disability from defiance. Imagine if suicide prevention strategies identified FASD as a high-risk population requiring tailored interventions. Imagine if the workforce were equipped with tools that actually fit the children and families they serve.

With recognition, access would mean not just more services, but the right services: care grounded in neurocognitive reality. Youth interventions could target emotional regulation and trauma alongside brain-based differences. Families could be supported, not blamed. And providers could experience success instead of burnout.

Mental health without FASD is like medicine without a diagnosis. Without naming PAE, these realities remain buried under generic labels like 'behavioral health needs.' Treatment systems keep aiming at shadows—never the root cause.

Until PAE is acknowledged, the nation will continue pouring resources into broken pipelines—offering bandages for wounds that never heal. Recognizing FASD is not optional; it is the cornerstone of any credible national mental health strategy.

Criminal Justice Outcomes

What MAHA Says

The MAHA Report advocates for trauma-informed care, enhanced reentry support, and diversion programs for justice-involved individuals. These are essential strategies.

What MAHA Leaves Out

Yet they remain incomplete without recognition of Prenatal Alcohol Exposure (PAE) and Fetal Alcohol Spectrum Disorders (FASD). Research shows that youth with FASD are up to 19 times more likely to be incarcerated than their peers.[45] This vulnerability stems not from defiance but from brain-based differences: difficulty connecting cause and effect, impaired memory, and struggles with understanding complex rules or legal processes.[45,46]

My son with FASD, unable to connect actions with consequences, has violated probation countless times for the same mistake. The court continues to see defiance; what no one recognizes is brain-based disability. Each violation pulls him deeper into a system that was never designed to understand him. Stories like this are repeated daily in juvenile courts across America —youth set up to fail, not because they are unwilling, but because their disability is invisible. The cost is staggering: repeated arrests, hearings, and incarcerations drain public resources while delivering no change in outcomes. Safety is not served, recidivism is not reduced, and communities bear the financial and the human burden of a revolving-door system.45 Until FASD is recognized, courts will keep punishing disability as if it were a choice, and the cycle will continue without end.~ Carl Young

The Consequences of Omission

Within today's justice system, staff are largely untrained in FASD. These brain-based differences are too often misinterpreted as defiance, manipulation, apathy, or lack of remorse.[47] What looks like lying may be memory impairment. What looks like resistance may be poor impulse control. Misinterpretation punishes disability as if it were choice.[48]

The result is a revolving door: repeated arrests, failed probation, incarceration, and reentry—none of which resolve the root issue. Safety is not served, recidivism is not reduced, and public resources are drained, while individuals with FASD are set up to fail.[49]

Evidence-Based Solutions

Imagine if every diversion program screened for FASD at intake, rerouting youth toward specialized supports rather than detention.[50] Imagine if probation officers were trained to adjust expectations, meeting individuals where they are instead of demanding compliance they cannot sustain.[51] Imagine if courts integrated accommodations—using screening tools and expert testimony to inform sentencing—so that disability was recognized instead of punished.[52] Imagine if reentry services were customized to lifelong cognitive and behavioral needs, lowering recidivism and enhancing public safety.[53]

Justice without FASD awareness is not justice at all.

Until PAE is named in national policy, courts will keep punishing symptoms, prisons will keep filling with the misunderstood, and families will keep watching their children slip through cracks that should never have existed.[54]

Educational Outcomes

Every classroom in America potentially holds children impacted by prenatal alcohol exposure—often more than one. They look like their peers, but their brains process the world differently. Without recognition, these students are almost aways mislabeled, misunderstood, and left behind.

Imagine if teachers were trained to see these differences not as defiance, but as disability. Imagine if schools had the tools to support memory, attention, and emotional regulation instead of relying on suspension and punishment. Imagine if every child, regardless of how their brain was wired, had a real chance to learn and thrive.

What MAHA Says

- Expand school-based mental health supports
- Increase access to counseling and early intervention
- Strengthen partnerships between schools and communities
- Promote student well-being and resilience

These are all urgent and worthwhile strategies—but none account for the prevalence and impact of FASD in school populations.

The Classroom Reality

FASD is one of the most common and most overlooked neurodevelopmental conditions in classrooms today:

- Prevalence estimates suggest FASD affects 1 in 14 of school-aged children, and PAE impacts 1 in 7, meaning most classrooms likely include at least one student with PAE/FASD.[52]
- Students with PAE/FASD often experience deficits in executive functioning, memory, processing speed, cause and effect, impulsivity, abstract reasoning, sensory issues, visual-spatial skills, high anxiety, delayed developmental timelines, and attention—difficulties that can mimic ADHD, autism, or other learning and behavioral disorders.[56]

High rates of co-occurring diagnoses (e.g., ADHD, ODD, ASD) contribute to frequent mislabeling, bouncing students from one false label to another and resulting in inappropriate interventions (lacking the right supports for success).[57]

"It took nine different schools before our son finally crossed the graduation stage. Again and again, teachers described him as smart but unable to follow directions or remember yesterday's lesson. Rewards and punishments made no difference—yet suspension after suspension crushed his spirit, until his self-esteem collapsed and simply walking through the school doors became a challenge." ~Joel Sheagren

Despite being widespread, FASD is nowhere mentioned within MAHA's discussion of school-based mental health.

When Interventions Backfire

Standard behavior management approaches often prove counterproductive for students with FASD. Reward-punishment systems and traditional disciplinary measures frequently fail because they rely on cause-and-effect and abstract reasoning that many students with FASD cannot consistently apply. Without understanding the neurological basis of these challenges, educators interpret learning and behavioral difficulties as defiance or lack of motivation.[58]

The Educational Consequences

- ***Mislabeling***: Youth are bounced from one diagnosis to another—ADHD, ODD, even "lazy"—while none of the supports match their real needs.[59]
- ***Failure of Standard Interventions***: Rewards and punishments often backfire because they rely on cause-and-effect reasoning that students with FASD cannot consistently follow.[60]
- ***Burnout***: Teachers and families, left without tools or explanations, experience repeated frustration and strain.[61]
- ***Exclusion***: Children with FASD face significantly higher rates of suspension, expulsion, and dropout, perpetuating long-term disadvantages.[62]
- ***Resource Waste***: Schools invest heavily in programs that prove ineffective for FASD, leaving students underserved and more likely to fall behind academically and socially.[63]

Evidence-Based Solutions

Imagine if every teacher were trained to recognize the signs of FASD. Imagine if early screening caught brain-based differences before years of misdiagnosis. Imagine if classrooms offered structure and repetition instead of punishment. Students with FASD could succeed—not in spite of their disability, but because schools finally understood how to support them.

- ***Early Identification***: Systematic screening within educational settings would reduce misdiagnosis and enable appropriate support planning.[64]

- ***Specialized Training***: Educators would receive strategies tailored to FASD learning profiles, including structured environments, repetition, scaffolding, and low-distraction approaches.[65]
- ***Adapted Services***: Special education programming would emphasize environmental modifications and neurocognitive accommodations rather than punitive discipline.[66]
- ***Family Collaboration:*** Stronger school-family partnerships would emerge when behaviors are understood as neurocognitive challenges requiring support rather than defiance requiring punishment.[67]
- ***Improved Outcomes***: With proper strategies, students would experience fewer suspensions, higher graduation rates, and stronger preparation for adulthood.[68]

Education without FASD awareness and training is misguided. Until FASD is recognized, millions of children will continue to be punished for the way their brains work. That is not education—it is exclusion.

The nation has invested heavily in student mental health, but without recognizing PAE, schools will continue to misdiagnose, mismanage, and marginalize millions of students. Naming and addressing FASD is not optional—it is the cornerstone of equitable and effective education policy.

Societal Outcomes

Walk through a homeless shelter, a child welfare docket, or a probation office—and you will find far too many youth and adults affected by FASD. The disability is hidden in plain sight, shaping outcomes that strain families, drain communities, and burden public systems as those impacted most often do not have physical traits to match their developmental disability.

Imagine if housing programs recognized FASD and built supports for stability. Imagine if child welfare workers understood brain-based disability before years of misdiagnosis and removal. Imagine if probation officers and community programs were equipped to meet youth where they are with the proper supports.

The MAHA Report calls for equity in access, stronger community partnerships, and investment in prevention. These are urgent priorities. Yet by omitting PAE/FASD, MAHA fails to address one of the most destabilizing roots of societal dysfunction.[69]

The Social Reality

FASD drives outcomes that ripple across every major system of care:

- ***Child Welfare***: Children with FASD are overrepresented in foster care and adoption systems, often removed due to misunderstood behaviors or caregiver strain.[70]
- ***Homelessness***: Studies suggest high rates of undiagnosed FASD among homeless youth and adults, tied to poor adaptive functioning, mental health challenges, and unemployment.[71]
- ***Exploitation and Trafficking***: Impulsivity, suggestibility, and difficulty understanding risk make individuals with FASD especially vulnerable to exploitation and trafficking.[72]
- ***Teenage Pregnancy***: Teens with FASD are at higher risk of early and unplanned pregnancies due to impulsivity, poor judgment, and vulnerability to peer pressure or exploitation. This creates a new generation at risk of instability—and, if alcohol is used during pregnancy, repeats the cycle of PAE.[73]
- ***Poverty***: Families impacted by FASD experience cycles of financial strain due to caregiving demands, unemployment, and systemic exclusion. [74]
- ***Public Safety***: Jody Crowe's Fatal Link found that as many as 80% of school shooters had probable or confirmed FASD, underscoring how missed recognition can escalate into broader safety crises.[75]

Note: This does not mean that individuals with FASD are destined for violence or instability—far from it. But it highlights how profoundly dangerous it is when neurodevelopmental disabilities go unrecognized and unsupported. The failure to identify and intervene does not only burden families; it creates tertiary effects that extend into schools, neighborhoods, and entire communities—where the costs are measured not just in dollars, but in lives.

Despite these realities, MAHA makes no mention of FASD in its strategies to strengthen communities, reduce inequities, or prevent crises.

The Consequences and Hidden Costs of Omission

Generational Impact: When FASD is unrecognized, its effects cascade across generations, perpetuating cycles of instability.[76,77]

- ***System Overload***: Schools, shelters, and social services are stretched thin by crises that could have been prevented through early recognition and targeted support.[78]
- ***Community Strain***: The failure to address PAE/FASD drains public resources, weakens resilience, and leaves communities less safe and less stable.[79]

My son chose to leave home at age 17 and has been homeless, jobless, as well as, in and out of prison ever since. He bounced between couches, shelters, and the street, not because he lacked will, but because no one recognized the brain-based disability that made independence nearly impossible without support. ~Carl Young

Evidence-Based Solutions

Imagine if equity initiatives included FASD as a recognized driver of disparity. Imagine if child welfare, housing, and community safety systems screened for PAE and responded with tailored supports. Imagine if prevention campaigns told the truth about prenatal alcohol exposure—the most preventable root cause of brain-based disability.

- ***Child Welfare Reform***: Screen for FASD in foster and adoption systems to reduce misplacement and ensure appropriate support.[80]
- ***Housing & Homelessness***: Provide supported housing models tailored to cognitive and adaptive needs.[81]
- ***Exploitation Prevention***: Train child welfare and law enforcement personnel to recognize vulnerabilities specific to FASD.[82,83]
- ***Equity Initiatives***: Prioritize FASD awareness in communities disproportionately impacted by poverty, trauma, and addiction.[84]
- ***Community Safety***: Integrate FASD recognition into violence-prevention and public safety initiatives, reducing preventable crises.[85]

Society without FASD awareness is inequity by design.

Until PAE is named, prevention efforts will remain partial, equity gaps will persist, and communities will keep paying the price in fractured families, wasted resources, and preventable tragedies. ***The tertiary effects are profound***: teenage pregnancies that continue the cycle of vulnerability, children entering foster care because their needs are misunderstood, young adults drifting into homelessness or exploitation, and families crushed by poverty that repeats across generations. These ripple effects weaken not only individual lives but the resilience of entire communities. Recognizing FASD is not optional—it is the cornerstone of building resilient, just, and thriving communities.

Societal Trends Worth Discussing

A further societal layer is the deliberate targeting of women by the alcohol industry. Marketing campaigns increasingly frame drinking as empowerment, self-care, or modern femininity—using pink packaging, "low-calorie" messaging, and the now-normalized "mommy wine culture." These campaigns glamorize alcohol use among women of childbearing age while ignoring the disproportionate health risks women face: higher vulnerability to alcohol-related cancers, liver disease, mental health challenges, and—most devastating of all—the harm caused to unborn children through prenatal exposure. This is not accidental; it is a profit-driven strategy that perpetuates gender stereotypes ***while fueling rising rates of alcohol-related harm among women and their children.*** (Movendi International, Big Alcohol Targets Women/ https://movendi.ngo/the-issues/the-problem/alcohol-harm-among-women/big-alcohol-targets-women/)

A research paper titled: *'Pretty in Pink' and 'Girl Power'*: An analysis of the targeting and representation of women in alcohol brand marketing on Facebook and Instagram. Their findings include: ...Claims by brands of a commitment to equality are at odds with the harms related to alcohol consumption that contribute to the widening of health and social inequalities... (Reference: https://doi.org/10.1016/j.drugpo.2021.103547)

Career Outcomes

Across the country, young adults with FASD who graduate, do so with hope—only to lose job after job to misunderstandings, dismissals, and disappointment. Employment is one of the clearest measures of independence, yet for many with FASD, the pathway to stability is blocked before it begins.

Imagine if employers were trained to see brain-based differences as disability, not defiance. Imagine if supported employment programs provided job coaching, structure, and mentoring. Imagine if every workplace had the tools to unlock the loyalty and capability of employees with FASD. With recognition and support, hope would not end at graduation—it would open into lifelong opportunity.

The MAHA Report links mental health to workforce participation and economic stability, stressing the importance of workplace supports, behavioral health integration, and reducing the costs of untreated mental illness. These are important goals. Yet by omitting PAE/FASD, MAHA misses a population whose employment struggles are both profound and preventable.

The Workforce Reality

- ***Employment Instability***: Studies show that up to 80% of adults with FASD experience chronic unemployment or underemployment throughout their lifetimes.[86]
- ***Executive Functioning Barriers***: Deficits in memory, time management, multi-step directions, and vulnerability to exploitation create barriers in traditional workplaces. Supervisors often misinterpret these challenges as laziness or noncompliance, leading to dismissals and wasted potential.[87,88,89,90,91]
- ***Dependence on Social Safety Nets***: Many adults with FASD rely on disability benefits or welfare, not from unwillingness to work, but because of systemic gaps in accommodation.[92]
- ***Untapped Potential***: With structured supports—clear routines, job coaching, and modified expectations—many individuals with FASD can succeed in employment.[93]

"My son with FASD has been hired several times, but within weeks loses the job—always for reasons tied to his adaptive skill deficits. In reality, he could excel with on-site support but the systems are not setup for this type of support." ~*Joel Sheagren*

Despite this reality, MAHA makes no mention of FASD in its strategies for workforce participation and economic stability.

The Consequences of Omission

- ***Lost Productivity***: Chronic unemployment and underemployment contribute to hidden workforce losses, adding to the estimated $22,810 per person per year in added costs associated with FASD.[94]
- ***Public Assistance Dependence***: High reliance on disability benefits and housing supports reflects gaps in supported employment opportunities.[95]
- ***Intergenerational Poverty***: Workforce instability perpetuates cycles of poverty that impact families and communities across generations.[96]

Evidence-Based Solutions

Imagine if workforce development programs included FASD-specific strategies. Imagine if job coaches and vocational rehabilitation were standard, not exceptions. Imagine if employer training reframed challenges as disability-based needs, not failures of character.

- ***Supported Employment***: Tailored programs could increase independence and reduce reliance on benefits.[97]
- ***Employer Training***: Businesses would learn to accommodate neurocognitive disabilities instead of dismissing them.[98]
- ***Vocational Rehabilitation***: Hands-on training, structured environments, and long-term mentorship would enable stability.[99]
- ***Policy Innovation***: Funding for job coaches, supported housing, and workplace accommodations could stabilize families and boost the economy.[100]

Ignoring FASD in workforce policy is both economic negligence and human negligence.

Employment outcomes for those with FASD are among the poorest of any disability, with devastating consequences for families and the economy.[101] Every missed job is lost productivity, deeper poverty, and another young adult stripped of dignity and purpose. Recognizing PAE/FASD is not optional—it is the cornerstone of a resilient and inclusive workforce.

Conclusion

The MAHA Strategy sets forth noble priorities for America's health crisis, yet it collapses under a critical omission: the failure to name PAE/FASD as a driving determinant of mental health and life outcomes.

Behind every statistic is a child suspended again, a teenager in juvenile court, a parent exhausted from blame, a professional who has compassion but not the tools, or a worker dismissed from yet another job. These are not isolated failures—they are the predictable outcomes of a system that refuses to name the root cause.

The evidence is overwhelming. FASD drives some of the highest rates of depression, suicidality, and treatment resistance in mental health. Youth are up to 19 times more likely to be incarcerated[102], punished for disabilities mistaken as choice. Students are mislabeled and excluded from schools unprepared to meet their needs.[103,104,105] Families are pulled into poverty, child welfare, and even community safety risks.[106,107] Adults cycle through chronic unemployment, their potential silenced.[108,109,110,111] The costs are staggering—for individuals, families, and the nation.

The MAHA Strategy now calls for prevention campaigns on alcohol, THC, and other risks. Yet it fails to name the most devastating and preventable form of alcohol harm: prenatal exposure. ***If MAHA is serious about addressing chronic disease, it cannot ignore the most preventable neurodevelopmental condition driving cycles of illness, inequity, and instability across generations.***

Imagine if national policy named PAE/FASD for what it is: the cornerstone of mental health, education, justice, workforce stability, and community resilience. Imagine if prevention campaigns told the truth about prenatal alcohol exposure, and schools, clinics, and courts were equipped to respond. Imagine if every child had a real chance to thrive, every parent a chance to be supported, and every community a chance to grow stronger.

Until PAE/FASD is recognized in national policy, America's health response will remain incomplete.

With recognition, we can shift from cycles of failure to pathways of hope. FASD is not a peripheral issue—it is the cornerstone of any credible national strategy. ***The time to act is now***.

About the Authors

Joel Sheagren and Carl Young are two fathers on a mission to transform how the world understands and supports neurodiverse families. Between them, they have raised children with FASD, autism, ADHD, and trauma—and turned personal challenges into a movement for systemic change.

Carl brings more than 20 years of policy advocacy, shaping laws at both the state and federal levels. Joel, an award-winning filmmaker and storyteller, harnesses the power of media to shift hearts and minds. Together, they co-created *Embracing Hope*, a book for a practical approach built on research, neuroscience, and kitchen-table wisdom—equipping families, schools, and communities with tools to move from survival to thriving.

Their work has grown into the ***Embraced Movement***—a multilayered media and advocacy project spanning books, film, technology, and training, bridging lived experience with real-world solutions.

This report is part of the Embraced Movement/Embracing Neurodiversity, LLC, a multilayered media project which includes:

- ***A Novel***: *Embracing Zak*—available on Amazon
- ***A Feature Film***: *Embracing Zak*—fundraising stage (EmbracingZak.com)
- ***A Documentary***: *Embraced: Truth About FASD*—planned as a prequel to the feature film, currently with a large archive of interviews. Samples at: EmbracedMovement.org
- ***A Caregiver Book***: *Embracing Hope*: *Innovative Strategies to Empower Parents Raising Neurodiverse* (ASD/ADHD/FASD/Trauma) *Teens*—available on Amazon and EmbracingHopeBook.com
- ***An App***: Hero's Embrace—in development
- ***Online Courses & Advocacy***: Practical training and resources for families and professionals

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Endnotes

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